2007 Legislation Overview
May 2007

Subject	Bill Summary or Background
OIC Request Legislation	
HB 1235 Confidentiality of certain insurance commissioner examinations	The existing specific exceptions for information obtained by the Commissioner in a financial or market conduct examination are extended to the information obtained by the Commissioner in the course of financial analysis or a market conduct desk audit. Chapter 126, Laws of 2007 Effective July 22, 2007
HB 1236 Capital and surplus requirements	The date on which the initial capital and surplus requirements apply is clarified to be when the insurer initially qualifies for authority to transact the various kinds of insurance. The ocean marine and foreign trade kinds of insurances are included as kinds of insurance for purposes of the initial capital and surplus requirements. The minimum basic surplus requirement is $2 million and $2 million required as additional surplus for ocean marine and foreign trade. It is clarified for domestic insurers that the capital and surplus requirements apply immediately upon acquisition or merger and that once attained, the capital and surplus requirements may not return to previous June 9, 1994, levels. Chapter 127, Laws of 2007 Effective July 22, 2007
HB 1293 Regulatory assessment fee provision	Changes regulatory assessment for HMOs to match assessment against insurers and HCSCs. For all companies providing health insurance in the state, including conventional insurance companies, health care service contractors, and health maintenance organizations, the regulatory fee imposed by the Insurance Commissioner cannot exceed one-eighth of one percent of the company's revenue in the state. Chapter 468, Laws of 2007 Effective July 22, 2007
SB 5042 Regulating the business of insurance	Chapter 80, Laws of 2007 Effective July 22, 2007
RCW 48.111.020	The $25 annual renewal fee for providers of home heating fuel service contracts is deposited into the state general fund.
RCW 48.12.010	The length of time that interest may be in default or taxes unpaid before the interest on the mortgage to which they apply is not counted as an asset, is shortened to 180 days, or about six months. The amortization period allowed for data processing and accounting systems allowable as assets is shortened to three years.
RCW 48.21.200	Fixes an impediment to providing coordination of benefits.
RCW 48.36A.260	Foreign and alien fraternal benefit societies are released from requirements to file annual statements with the Commissioner. They must file annual statements only with NAIC in electronic form.
Title 48.11 RCW	The definitions of ocean marine and foreign trade insurances are moved from the chapter of law concerning fees and taxes to the chapter of law concerning insuring powers where other types of insurance are defined.
RCW 48.13.120	It is clarified that to be counted as an asset owned by the insurer, an investment in a first mortgage of residential real estate must not exceed 80 percent of the market value of the real property.
RCW 48.13.265	It is clarified that mortgage-backed securities qualifying under the secondary mortgage market enhancement act of 1984 are counted toward the 65 percent limitation applying to the amount of an insurer's assets that may be held in real estate.
RCW 48.13.275	It is clarified that the quality-assurance requirements do apply to SVO-rated obligations in which insurers invest.
RCW 48.24.070	The participation requirements for trustee group life insurance have changed. The premium requirement for a trustee group life policy is changed to allow the insured to contribute all of the premium for his coverage. The seventy five percent requirement is eliminated. The number of persons the policy must cover at issue is decreased from 50 to 20.

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RCW 48.31.045 and RCW 48.31.131	The statute of limitations for a rehabilitator to institute an action on behalf of the insurer is the later of two years or two years from the discovery of the injury from which the cause of action arises. It is clarified that actions brought against the insurer's directors, officers, or employees for the benefit of the insured or the general public are not subject to limitation. The same limitations apply to actions by liquidators.
RCW 48.31.155	Rather than being deposited with the State Treasurer, unclaimed funds from a liquidation of an insurer are deposited with the Department of Revenue.
RCW 48.43.018	Language that presupposes that a health insurance policy might be discontinued in the process of conversion is stricken.
RCW 48.22.030	The inadvertent mistake that occurred during the last legislative session is corrected. AK.A – Ethel's Bill correction.
RCW 48.12.120	Duplicative requirements for unallocated liability loss expense in workers' compensation are repealed.
SSB 5263 Medical Malpractice	Modifies medical malpractice closed claim reporting requirements to require providers that purchase medical malpractice insurance through risk retention groups (RRG) to report directly, or to negotiate with the RRG to report on their behalf. Chapter 32, Laws of 2007 Effective July 22, 2007
SSB 5715 Producer licensing	Based on the NAIC Producer Licensing Model act, the bill reforms and modernizes agent, broker, and adjuster license processing and administration. The legislation promotes simplification and streamlining of the licensing process. Advances reciprocity and uniformity with other states' insurance licensing laws. For more specific information see the final bill report at: http://www.leg.wa.gov/pub/billinfo/2007-08/Pdf/Bill%20Reports/Senate%20Final/5715-S.FBR.pdf Chapter 117, Laws of 2007 Effective July 1, 2009
ESSB 5717 Market conduct oversight	Based on an NAIC Model Act, creates a market conduct oversight program that replaces the existing market conduct program. Provides the OIC with the information and methods necessary to monitor the state's insurance marketplace, identify trends, changes and emerging issues to target insurers for regulatory intervention and to allocate resources where they can be most effective to protect consumers. For more specific information see the final bill report at: http://www.leg.wa.gov/pub/billinfo/2007-08/Pdf/Bill%20Reports/Senate%20Final/5717-S.FBR.pdf Chapter 82, Laws of 2007 Effective: July 22, 2007
"Other" Legislation	
SHB 1233 Fixed payment insurance	Addresses specified disease, hospital confinement, or other fixed payment insurance. The OIC delivers a report on fixed payment insurance products to the legislature each June, beginning June 1, 2009. The report will focus on the groups and enrollees purchasing these products and upon the number of consumer complaints. Chapter 296, Laws of 2007 Effective July 22, 2007
SHB 1337 Colorectal cancer exam coverage	Requires health plans issued or renewed on or after July 1, 2008 to provide benefits or coverage for colorectal cancer examinations and laboratory tests specified in the U.S. Preventive Services Task Force or the federal centers for disease control and prevention. Chapter 23, Laws of 2007 Effective July 22, 2007
EHB 1460 Mental health parity	Requires mental health services be mandated after January 1, 2008 for individual, WSHIP and small group plans that provide coverage for medical and surgical services. The co-payment or coinsurance for these services may be no more than the co-payment or coinsurance for medical and surgical services otherwise provided under the plan. If the plan imposes a maximum out-of-pocket limit

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	or stop loss, it shall be a single limit or stop loss for medical, surgical and mental health services. Prescription drugs used to treat mental health services must be covered under the same terms and conditions as other prescription drugs. After July 1, 2010, if a deductible is imposed, it shall be a single deductible for medical, surgical and mental health services. Treatment limitations or any other requirements are imposed on coverage for medical and surgical services. Chapter 8, Laws of 2007 Effective January 1, 2008
E2SHB 1569 Improving health insurance coverage in Washington state.	Sec. 15 The Office of the Insurance Commissioner (OIC) shall contract for an independent study of health benefit mandates, rating requirements, and insurance statutes and rules to determine the impact on premiums and individuals' health if those statutes or rules were amended or repealed. The interim report to the governor and appropriate committees of the legislature is due by December 1, 2007, and a final report by December 1, 30 2008. The Partnership Board is required to consult with the OIC and others in developing the health insurance partnership, and the Health Care Authority must consult with the OIC when developing rules for the method of paying subsidies in the partnership. For more detailed information about this legislation, go to : http://apps.leg.wa.gov/billinfo/summary.aspx?bill=1569&year=2007 Chapter 260, Laws of 2007 Laws PV Effective July 22, 2007
1953 Requiring premium reductions for older insureds completing an accident prevention course.	Amends RCW 48.19.460 An eight-hour course meeting the criteria of the DOL may be offered via an alternative delivery method of instruction. An alternative delivery method of instruction may include internet, video, or other technology-based delivery methods. An agency seeking approval from the DOL to offer an alternative delivery method course of instruction is not required to conduct classroom courses. An alternative delivery method course of instruction is not limited to areas where a classroom course is not offered. The DOL may adopt rules to ensure that drivers take and complete courses delivered by alternative methods. Chapter 258, Laws of 2007 Effective July 22, 2007
SSB 5052 Prohibiting interested third parties from processing insurance claims. (Auto glass)	The relationship between the customer and the auto glass repair facility that is the third-party administrator for the insurance company is regulated by the Office of the Insurance Commissioner. The customer's right to choose any auto glass facility is declared. Verbal disclosure from the third-party administrator to the customer that the customer has the right to choose and that the third-party administrator is a separate entity from and has a financial arrangement with the insurer is required. In addition, it is required that: (1) a written notice of the verbal disclosures in each repair facility owned by an insurer or third-party administrator is posted, and prior, verbal transmission to the customer if the transaction is done by a mobile facility; (2) the right to file a complaint with the Office of the Insurance Commissioner is given to the customer; and (3) it is stated that no private right of action is created. Chapter 74, Laws of 2007 Effective July 22, 2007
2SSB 5093 Access to health care services for children	Adds a new section to Chapter 48.43 RCW stipulating that when DSHS has determined that it is cost-effective to enroll a child participating in a medical assistance program in an employer-sponsored health plan, the carrier must permit enrollment of the participant who is otherwise eligible for coverage in the health plan without regard to any open enrollment restrictions. Chapter 5, Laws of 2007 Effective July 22, 2007

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ESSB 5292 Physical therapist assistants	A new section is added to RCW 48.43.045 that clarifies that insurers are not required to contract with physical therapist assistants; the requirements that health carriers permit every category of provider do not apply to physical therapist assistants. Chapter 98, Laws of 2007 Effective July 1, 2008
SSB 5435 Creating the public records exemptions accountability committee.	The purpose of the Committee is to review public disclosure exemptions and provide recommendations. The Committee must develop and publish criteria for review of public exemptions. The Committee must develop a schedule to accomplish a review of each public disclosure exemption. The Committee must publish the schedule and publish any revisions made to the schedule. For each public disclosure exemption, the Committee must provide a recommendation as to whether the exemption should be continued without modification, modified, scheduled for sunset review at a future date, or terminated. By November 15 of each year, the Committee must transmit its recommendations to the Governor, the Attorney General, and the appropriate committees of the Legislature. Chapter 198, Laws of 2007 Effective July 22, 2007
SSB 5503 Licensing persons who offer athletic training services.	Athletic trainers are exempt from the requirement that health carriers cover every category of Provider. Chapter 253, Laws of 2007 Effective July 1, 2008
2SSB 5597 Contracts with chiropractors	Health carriers are required to reimburse chiropractors for medically necessary services if the service is covered chiropractic health care and it is provided by the chiropractor or an employee who works at the same location. Violations of the participating provider agreement by an employee of the chiropractor are deemed to have been committed by the chiropractor. Participating provider agreements provided to a chiropractor within a sole proprietorship, partnership, or corporation must be offered to any other chiropractor within that practice at the same location. Chapter 502, Laws of 2007 Effective January 1, 2008
ESSB 5726 Insurance fair conduct act	Allows first party claimants to an insurance policy may sue insurers for unreasonable denials of coverage or payments of benefits. First party claimant is defined as an individual, corporation, association, partnership or any other legal entity who asserts the right to payment as a covered person under the insurance policy at issue. Damages are available to plaintiffs upon a finding that the insurer unreasonably denied coverage or payment. A plaintiff may also recover damages if the insurer violated one of five rules adopted by the Office of the Insurance Commissioner (OIC) or any additional rules that the OIC adopts that are intended to implement this act. The five WAC rules regulate insurers' actions in the following areas: (1) specific unfair claims practices; (2) misrepresentation of policy provisions; (3) failure to acknowledge pertinent communications; (4) standards for prompt investigation; and (5) standards for prompt fair and equitable settlements. Upon finding a violation of the act, the court must award: (1) the actual damages sustained; (2) reasonable attorney's fees; and (3) actual and statutory litigation costs, including expert witness fees. The court has the discretion to also increase the total award of damages to an amount that does not exceed three times the actual damages suffered by the plaintiff. Health carriers are exempt from this bill. A claimant must provide 20 days written notice to both the insurer and the OIC before filing suit under this section. The notice must provide the basis of the cause of action. If the insurer does not resolve the claim during that 20-day period, the claimant may then bring suit without any further notice. Chapter 498, Laws of 2007 Effective July 22, 2007

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SSB 5919 Retaliatory taxes	Changes the word "fee" to "regulatory surcharge" when referring to the amount that the Insurance commissioner charges insurers to pay the operating costs of the OIC. Explicitly states that the regulatory surcharge is not part of a policy's premium. Creates a mechanism for recouping the amount of regulatory surcharge paid in previous years from policy holders at a uniform rate separately listed on bills or policy declarations. Chapter 153, Laws of 2007 Effective July 22, 2007
E2SSB 5930 Providing high quality, affordable health care to Washingtonians based on the recommendations of the blue ribbon commission on health care costs and access.	Sec. 17. By December 1, 2007, the insurance commissioner shall provide a report to the governor and the legislature that identifies the key contributors to health care administrative costs and evaluates opportunities to reduce them, including suggested changes to state law. The report shall be completed in collaboration with health care providers, hospitals, carriers, state health purchasing agencies, the Washington healthcare forum, and other interested parties. Sec. 19 – 22. all insurance carriers and state employee programs must offer an opportunity to extend coverage to unmarried dependents up to age 25, effective January 1, 2009 Sec. 25. The office of financial management, in collaboration with the office of the insurance commissioner, shall evaluate options and design a state-supported reinsurance program to address the impact of high cost enrollees in the individual and small group health insurance markets, and submit an interim report to the governor and the legislature by December 1, 2007, and a final report, including implementing legislation and supporting information, including financing options, by September 1, 2008. Sec. 26. WSHIP modifications include benefit limits to reflect inflationary changes, and an increase in the lifetime maximum to $2 million to be effective immediately. All policies offered through WSHIP will be cancelled before December 31, 2007, and replaced with identical policies that allow for a guarantee of the continuity of coverage. Future policies can be replaced but must include the services covered under the replaced plan. Age restrictions for premium assistance for low-income enrollees are removed. By December 1, 2007, the WSHIP Board must have an analysis of eligibility completed that will review eligibility for Medicaid enrollees, other publicly sponsored enrollees, and an assessment of the 8 percent eligibility threshold used for screening people out of the individual market and into the high risk pool. The standardized screening questionnaire used for the individual market and high risk pool will be required for individuals applying for nonsubsidized Basic Health, and additional groups with creditable coverage, such as federal government or church sponsored coverage, will not be required to complete the screen. The enrollment limit linked to 2003 enrollment levels for Evergreen Health Insurance Program enrollees is removed. Immunity protections are provided for WSHIP employees and members of the Board. For more detailed information about this legislation go to: http://apps.leg.wa.gov/billinfo/summary.aspx?bill=5930&year=2007 Chapter 259, Laws of 2007 PV Effective July 22, 2007*
E2SSB 5958 Creating innovative primary health care delivery	Direct patient-provider primary care practices are explicitly exempted from the definition of health care service contractors in insurance law. Standards describing the direct practices are placed in Title 48 insurance laws; however, the direct practices are not insurance carriers, and they may not sell their product to groups like an insurance carrier. Direct practices must register annually with the Office of Insurance Commissioner (OIC), and the Commissioner will be the lead agency for consumer protection concerns. Beginning December 1, 2009, the OIC must report annually to the Legislature on direct care practices, including participation trends and complaints received. By December 1, 2012, the OIC must submit a study of direct care practices to the Legislature, including the impact on access to primary health care services, premium costs for traditional health insurance, and network adequacy. Chapter 267, Laws of 2007 Effective July 22, 2007
Budget Provisos That Require Action	

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1128 SHB Fiscal matters	Sec. 308. (11) $40,000 of the general fund--state appropriation for fiscal year 2008 and $40,000 of the general fund--state appropriation for fiscal year 2009 are provided solely for the Department of Natural Resources to convene and staff a work group to study issues related to wildfire prevention and protection. The work group shall be composed of members representing rural counties in eastern and western Washington, fire districts, environmental protection organizations, industrial forest landowners, the agricultural community, the beef industry, small forest landowners, the building industry, realtors, the governor or a designee, the insurance commissioner or a designee, the office of financial management, the state fire marshal or a designee, the state building code council, and the commissioner or public lands or a designee. The work group shall issue a report of findings and recommendations to the appropriate committees of the legislature by August 1, 2008. Sec. 902. INFORMATION SYSTEMS PROJECTS. Requires that agency planning and decisions concerning information technology be made in the context of its “information technology portfolio”. Information technology portfolio means a strategic management approach that links technology efforts to agency objectives and business plans, analyzes the impact of new investments on existing infrastructure and business function, and ensures that agency activities are consistent with the development of an integrated, nonduplicative statewide infrastructure. Sec. 1621. Creates a centralized “Information Technology Funding Pool” under the control of the department of information (DIS) and office of financial management (OFM). DIS shall review information technology proposals and work jointly with OFM to determine the projects to be funded and the amounts and timing of release of funds. Chapter 522, Laws of 2007 PV Effective May 15, 2007